The Commission on Acute Adult Psychiatric Care

The Commission to Review the Provision of Acute Inpatient Psychiatric Care for Adults in England, Wales and Northern Ireland

Call for evidence

The Commission to review the provision of inpatient psychiatric care for adults in England, Wales and Northern Ireland

Call for Evidence

The Commission

The Commission to review the provision of inpatient psychiatric care for adults in England, Wales and Northern Ireland has been set-up in response to concerns about whether there are sufficient acute inpatient psychiatric beds and alternatives to admission available for patients and service users.

The Commission met for the first time in January 2015, and will be spending the next year gathering evidence and considering care in England, Wales, and Northern Ireland (Scotland is not included, as a separate programme of work is currently being undertaken by other organisations on the same issue). The Commission will produce its final recommendations in January 2016.

More information about the Commission can be found at www.CAAPC.info. The Commission receives administrative support from the Royal College of Psychiatrists, but has agreed its own terms of reference and will operate independently.

Our Call for Evidence

The Commission is beginning its work by asking all individuals and organisations in England, Wales, and Northern Ireland with relevant knowledge and experience for their help by completing this consultation. This includes all:

- Patients/service users
- carers and family members
- members of staff in mental health services (NHS, independent, or voluntary)
- providers of mental health services (NHS, independent, or voluntary)
- commissioners or planners of mental health services
- individuals and organisations involved in health or social care outside of mental health
- primary and secondary care staff (clinical and managerial)
- charities or voluntary sector organisations with an interest in this area
- individuals or organisations working in the criminal justice system
- Local Authority Bodies and individuals working for them
- Other relevant bodies or groups

Responses will be used to inform the Commission's areas of inquiry and final recommendations.

Call for Evidence Closing Date: 18th March
Please complete this consultation and email it to consultation@CAAPC.info

Responses can also be sent by post to:

Commission on Acute Adult Psychiatric Care
c/o The Royal College of Psychiatrists
21 Prescot Street
London
E1 8BB

If you have any questions about the consultation or about the Commission, please contact information@caapc.info

What this consultation covers

In this consultation, we use the terms

- **"mental health inpatient care" to describe**:

  "a unit with beds that provides 24-hour nursing care, and which can provide care for patients detained under the Mental Health Act. Such inpatient units can be provided by the NHS or by other providers."

- **"alternatives to inpatient care" to describe:**

  "alternatives to admission into an inpatient unit. This can include Crisis Resolution and Home Treatment Teams, Crisis Houses, Acute Day Services and other services."

What this consultation does not cover

The consultation does not cover (a) services for children or adolescents or (b) services for people with dementia.

The consultation does not cover specialist inpatient services, unless the evidence directly relates to the provision of mental health inpatient care/alternatives to inpatient care. An example of this would be an issue relating to the transfer of care between specialist inpatient services and non-specialist inpatient services.

Specialist inpatient services are commissioned/provided at the national rather than local level. They include, for example, mother and baby beds, forensic inpatient services, and eating disorder beds.

Questions

Q1.
In your opinion, what is the **value** and **purpose** of inpatient mental health care for adults?

We are interested in hearing your views on the importance, worth, or usefulness of inpatient care. Please explain your answer (*word limit 500 words*).

The RCN believes that the provision of Acute Adult In Patient Psychiatric Care is essential to those who by virtue of a crisis in their mental health require skilled well resourced and evidence based care and treatment. We believe that mental health nurses have an essential part to play in this process, by their leadership of the nursing team in those environments, but also the leadership and management they provide 24 hours a day 365 days a year to those who reside and work in those environments.

We consider that such environments when skilfully managed and led, can provide a place not only of safety but also a place to commence or recommence the individuals pathway of recovery.
Our members were keen to articulate the value of in-patient beds and unsurprisingly saw the virtue in its current emphasis on safety and described the ability to "maintain the safety of the individual service user and those around them when alternatives to admission are not possible".

This was possibly best described in specific environments such as psychiatric intensive care units where "the environments have a demonstrated ability to contain often dangerous and/or very challenging individuals until either they are more manageable or alternative arrangements have been found."
The characteristics of PICUs were described by one member as
"A PICU has fewer beds, generally higher staff ratios, and a smaller and more coherent architecture than the acute wards. We have extra care areas and seclusion rooms should these be required. There are more rules than on the open wards and it thus straddles to a certain extent the acute and forensic pathways – individuals who have prior forensic backgrounds sometimes find it easier accommodating themselves to the greater structure of this ward."

However there has been argued to be an increasing acuity in in-patient settings and the greater emphasis on security and risk management has led to most in pt areas whilst not being PICUs being a locked and secure environment. So the value and purpose of an in pt ward whilst not formally a PICU has now been transformed to a secure place where the very ill and vulnerable are treated and cared for in an environment of safety. There is clear value in this safety and recognising the acuity means the purpose is now focussed on shorter length of stays driven by a desire to assess the client, initiate treatment and when adherence and stability is gained then seek discharge.

Members articulate that the level of acuity and turnover of clients creates a very arduous environment to both reside and work in. The emphasis on short length of stays and the reduction of beds has transformed the acute in pt area to focus on possibly a single modality of treatment and to neglect other aspects of treatment and care such as psycho social interventions with both the client and their families and carers. A purpose of admission that is increasingly rare to receive.

The next questions are about your *experience* of mental health inpatient care, or alternatives to inpatient care.

This experience could come from working in health and social care, receiving inpatient or alternatives to inpatient care yourself, or knowing or caring for someone who has.

Q2.

Please can you provide an example of:

- '**good**' inpatient care
- '**good**' alternatives to inpatient care?

Please explain your answer, and give as much detail as possible about what made the care 'good'. Please also tell us ***where*** and ***when*** this example is from (e.g. *Manchester, 2012*).

Good inpatient care (500 WORD LIMIT)
The current and growing division between acute in pt care and community care is argued by some to frustrate the purpose of acute in pt wards where the patient is not known and discharged back to a community psychiatrist who upon reviewing the person with their new medication regimen will then consider a change now the acute phase is over.
One member states how when there was continuity between in pt care and community this promoted a far better outcome. He/she argues that
"Safe staffing levels, a stable workforce, Consultant Psychiatrists who are permanent, not Locum and who are in full-time positions with perhaps jobs which are related - e.g. Consultant from an in-patient ward, also then sees the same patients in the community too – London 2001

Good in patient care is considered to be that that is adequately staffed with a continuity of relationships , where there are meaningful activities driven by service user choice and facilitated by motivated staff. A homely and non clinical setting with access to fresh air and modern and in good repair. Such an environment can be found in the in-patient facilities in Grimsby.
Another aspect of care and treatment that is considered successful is when it is focussed on evidence based interventions and the SafeWards initiative exemplified by the work of prof Len Bowers (2014) We would recommend that the commission specifically seek an evidence session to hear of his work over the last 20 years in promoting safe and effective care.

Good alternatives to inpatient care (500 WORD LIMIT)
Alternatives to admission blossomed under the National Service Framework (1999). The proliferation of teams (assertive outreach, home treatment, early intervention) has now been followed by a retraction driven by service reconfiguration. However one member stated
"Crisis Resolution Team - again when staffing levels were adequate, when they have the capacity to undertake home visits in two's to aid decision making as well as staff and patient safety.
When they had the time to engage in home treatment rather than just assessing for whether or not someone needed admission.

London 2002-2010"

Other alternatives must include those environments that are less clinical yet that provide respite and care in crisis such as Crisis Houses, and also the development of peer support workers that assist the client to maintain their well-being beyond admission. The research work of Alan Simpson at City University is again a resource to consider. Alternatives can be consider upon the actual admission and the development of relapse signatures and crisis plans as exemplified in the care and treatment plans required by the mental Health Measure in wales are such an example of pre emptive planning.

Q3.
Giving as much detail as possible, please can you:

- provide an example of '**poor**' inpatient care
- explain how that poor inpatient care could be **improved**?

Please explain your answer, and give as much detail as possible about what made the care 'poor'. Please also tell us ***where*** and ***when*** this example is from (e.g. *Cardiff, 2014*).

Poor inpatient care (500 WORD LIMIT)
Here I have placed the responses of members which speak for themselves

"Staff working long days as opposed to shorter shift patterns - leading to lack of continuity of care and staff burnout.
Poor ward environments – poor decoration and shoddy maintenance.
Uninviting and unimaginative Occupational Therapy programmes – e.g. Newspaper Group.
Psychology and OT only seeing patients when they are 'well' – i.e. not in reaching to those patients who perhaps are not well enough to have leave at the time.
Lack of security therefore illicit drugs being brought on to the wards.
London, 2014

Another RCN member offered
Family members frequently feel that their father etc is admitted too late, sometimes to a unit a long way from their home (especially if sent to a private out of area unit due to capacity issues), and sometimes are angry that leave is given too early or that discharge occurs too soon.
Once on the ward a patient might easily be confused by a changing array of doctors who see them for a short period once a week and are often focused on what may appear to be arcane matters. Medication is at the heart of contemporary psychiatry and is the source of numerous conflicts. From an individual perspective patients often complain of being over medicated, of being bored on the ward due to lack of activities, feel their psychological needs are not being addressed, and often are unhappy about being around a lot of other 'unwell' people.
From the patients perspective care is often seen as poor because they are cajoled or forced into taking medication they do not want. From a system perspective there are often very good reasons for these actions – at times, we believe, only the enforcement of medication can manage the acute distress a person is manifesting and it would be cruel not to do so.

How could that poor inpatient care be improved? (500 WORD LIMIT)
One member of the RCN offered the view that

"For society to decide more clearly (as psychiatry fundamentally follows social norms not sets them) who it thinks has a 'mental disorder' and should be admitted to hospital and plan services accordingly – should young males who have been abusing amphetamines, don't wish to stop, and are aggressive and impulsive, be placed in a population of other patients who are vulnerable and distressed?"

This raises possibly the question about in patient services that evades current definition and which when answered could correct what are seen as the deficiencies of current models of in-patient care.
Namely what is it for? We wonder whether there is a clear vision of the purpose, and this is why the Commissions' task is so welcome.
One solution that could address this issue is a recognition that acute in patient care is a speciality in its own right. It is not what you do before undertaking a different role in the community. As a specialism with its own evidence base and following the PICU model possessing a national association it could truly achieve the status it requires. We suggest that there is no current venue for best practice sharing and advancement of the science and craft of acute care. The need for such a forum has never been greater.

Q4.

Giving as much detail as possible, please can you:

- provide an example of a '**poor**' alternative to inpatient care
- explain how that poor alternative to inpatient care could be **improved**?

Please explain your answer, and give as much detail as possible about what made the care 'poor'. Please also tell us ***where*** and ***when*** this example is from (e.g. *Belfast, 2013*).

Poor alternative to inpatient care (500 WORD LIMIT)

One member offered this view, highlighting the challenges that occur when out of area placements occur, an increasingly common problem.

"I currently work for a Priory Hospital. We are, in effect, an overflow facility providing in-patient care for those requiring acute psychiatric care when the service users' locality is unable to provide provision at that time. Although this is not always problematic for service users- some recognise there are social/domestic factors that they wish to escape from; for many, however, being a long distance from home can only add additional pressure to what is an already stressful situation. For some, this creates additional problems to overcome, such as the cost of transport for visits, and complications when making arrangements with other agencies, such as Social Services/Housing departments. Furthermore, relatives may struggle in trying to visit their loved ones, exacerbating feelings of isolation and guilt.
As I have mentioned, out-of-area placements might actually benefit some service users, but this is clearly not part of the initial referral procedure, and when benefits do arise from the situation, this is mostly by chance."

How could that alternative to poor inpatient care be improved?

The RCN considers that there should be a local assessment of need based upon a population profile and that sufficient resources are provided to meet the needs of a defined local population. There should not be the need to admit patients many miles away from their home and support networks, this is going to add to a sense of isolation and exacerbate the alienation than can be experienced in times of acute illness.
This is clearly a role for local commissioning groups to consider

Q5.

In your opinion, what would be the **best way of measuring 'good quality' care** on an inpatient ward, or in an alternative to inpatient care?

In other words, what should we measure? And how should we measure it?

Good quality care is best measured by the lived experience and subsequent perceptions of the service users themselves. Whilst acutely unwell there may be sufficient cognitive impairment to make this an unlikely task, but that situation can be sufficiently rectified soon enough for the questions to be asked.
Whilst clinicians may expend their efforts on the control and management of symptoms the patient may well soon express a different agenda
Therefore we propose that a good service will provide a model of care that will reach beyond the immediate issues and prospectively work with the patient and their carers on longer term matters related to personal goals and aspirations in the pursuit of a good quality of life.

Q6.

In your experience, do inpatient wards and alternatives to inpatient care services work well for all patients/service users? Or are there some groups (such as adults from some BME communities or other adult groups) that inpatient and crisis services do not work well for? Please give as much detail as possible.

A member offered this view about services for specific client groups.
"I think there has been a lot of work done on this – issues are more likely to arise when patients are sent to units a long way from home....there is a class aspect to this as well as a potential BME aspect; family often struggle to see their relatives because they cannot physically get there, they have no car, the bus service is poor etc.
I think that there are specialised populations who are not well suited to inpatient units and benefit from more experienced networks – those diagnosed with personality disorder pre-eminently. Such individuals may also struggle with the crisis teams due to the inevitable changing of staff involved and the management of expectations. The same may apply to people with autism and/or comorbid disorders who need structure and reliability in personal but who at the same time struggle with the structure – and noise and disruption - of the acute wards.
Some individuals may like the structure of the inpatient wards too much and thus they serve little therapeutic function, merely reinforcing pre-existing needs – people with experience in prisons stand out in this regard. Better probationary or other structures may be more appropriate here."
For society to decide more clearly (as psychiatry fundamentally follows social norms not sets them) who it thinks has a 'mental disorder' and should be admitted to hospital and plan services accordingly – should young males who have been abusing amphetamines, don't wish to stop, and are aggressive and impulsive, be placed in a population of other patients who are vulnerable and distressed?
"

Q7.

We are keen to hear about any examples of good practice, service evaluations, research reports, data-sets, or other information that would help the Commission in its work.

Please take the opportunity below to let us know where we could obtain this information, including any contact details of the organisation/person that it can be obtained from.

The RCN would propose that the following resources are considered by the Commission

The acute in patient accreditation service offered by the Royal College of Psychiatrists (AIMS)

The Safewards initiative from Kings College London and authored by Professor Len Bowers, this provides a distillation of 20 years of in patient research and offers a evidence based approach to coercion and containment reduction

Starwards the work of Marion Janner and the Bright Charity and its focus on ward based improvements that are cost effective, free to obtain and successfully implemented

Six Core Strategies, violence and restrictive intervention reduction programme being implemented by Professor Joy Duxbury a mental health nurse academic at the University of Lancaster

Important – please turn to the next page and complete your consultation contact details

About you (please complete in full)

Q8. Please provide your full contact details below. We will not use these for any other purpose than to understand who has responded to the consultation, and to produce an overall 'count' of the different types of respondents. We will not share your details with any other organisation.

Your name:	Ian Hulatt
Your job title (if relevant):	Professional lead for mental health
Organisational name (if this applies):	Royal College of Nursing
Address:	20 Cavendish Square
Post code:	W1G ORN
Email:	Ian.hulatt@rcn.org.uk
Telephone number:	07909907013

Q9. Are you replying to this consultation:

X on behalf of an organisation?

Q10. Which of these best describes your experience of, or interest in, inpatient mental health care:

☐ As a patient, service user, or survivor
☐ As a carer or family member
☐ As a member of staff in a mental health service (NHS, independent, or voluntary)
☐ As a provider of mental health services (NHS, independent, or voluntary)
☐ As a commissioner/planner of mental health services
☐ As someone involved in health or social care outside of mental health (clinical and managerial)
☐ As a charity or voluntary sector organisation with an interest in this area
☐ As an organisation or individual working in the criminal justice system
☐ As a Local Authority body (or an individual working for them)
x☐ Other (please specify)

_Royal College of Nursing_____

Q11a. Thinking about the answers you gave in this consultation, where has your experience of inpatient services/alternatives to inpatient services mainly taken place?

The answers have been collated from our members who responded to the emailing of the Consultation questions. We assured them of anonyminity.

☐ England ☐ Wales ☐ Northern Ireland

Q11b. And in which region?

☐ North East England
☐ North West England
☐ Yorkshire and the Humber
☐ East Midlands
☐ West Midlands
☐ East of England
☐ London
☐ South East England
☐ South West England
☐ West Wales/Valleys
☐ East Wales
☐ North Wales
☐ Mid Wales
☐ South West Wales
☐ South East Wales
☐ Belfast
☐ Outer Belfast
☐ East of Northern Ireland
☐ North of Northern Ireland
☐ West and South of Northern Ireland

Q12. Would you be happy for us to contact you to ask for further information about your response?

☐ Yes

Finally, if you are replying as an individual (rather than as an organisation):

Q13. What is your gender?

☐ Male
☐ Female
☐ Transgender
☐ Prefer not to say

Q14. Please tick your age group

☐ 19 or under
☐ 20 to 29
☐ 30 to 39
☐ 40 to 49
☐ 50 to 59
☐ 60 to 69
☐ 70 or over
☐ Prefer not to say

Q15. Would you consider yourself to have a mental health problem?

☐ Yes – I would consider myself to currently have a mental health problem
☐ Yes – I would consider myself to have had a mental health problem in the past
☐ No
☐ Prefer not to say

Q16. How would you describe the area in which you experienced inpatient care?

☐ City
☐ Rural
☐ Town
☐ Inner city
☐ Suburban
☐ Prefer not to say

Q17. How would you describe your ethnic origin? Please tick one box only.

White
☐ White – English/Scottish/Northern Irish/British
☐ White – Irish
☐ White – Gypsy or Irish Traveller
☐ White – any other White background

Mixed/multiple ethnic groups
☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Any other mixed/multiple ethnic background

Asian/Asian British
☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Chinese
☐ Any other Asian background

Black/African/Caribbean/Black British
☐ African
☐ Caribbean
☐ Any other Black/African/Caribbean background

Other ethnic group
☐ Arab
☐ Any other ethnic group
☐ Prefer not to say

Thank you for your help
Please return this questionnaire by 18th March to consultation@CAAPC.info or to the postal address on the first page of this document
If you have any questions about the Consultation or about the Commission, please contact information@caapc.info